EARLY INTERVENTION FOR ALCOHOL USE: FAMILY PHYSICIANS' MOTIVATIONS AND PERCEIVED BARRIERS

Brian R. Rush, PhD; Lysbeth Y. Powell, MA;
Todd G. Crowe, MSc; Kathleen Ellis, MSc

Abstract • Résumé

Objective: To elucidate family physicians' motivations concerning early intervention for alcohol use and their perceived barriers to such intervention.

Design: Qualitative study with the use of focus groups and semistructured interviews.

Setting: Community-based, fee-for-service family-medicine practices in London, Ont.

Participants: Twelve focus-group participants recruited through telephone contact by two family physicians on the project team. Participants were required to be physicians in family practice in London. Twelve interview participants recruited through a grand-rounds presentation at two local hospitals. Participants were required to be physicians in a community-based family practice in which primary care was not delivered by residents and to have agreed to participate in all phases (e.g., needs assessment, training and evaluation) of a training program on interventions to help patients reduce alcohol consumption or quit smoking.

Main outcome measures: Motivations concerning early intervention for alcohol use and perceived barriers to such intervention, as identified by physicians.

Results: Physicians in the focus groups and those interviewed endorsed their role in helping patients to reduce alcohol consumption and cited several reasons for the importance of that role. There was strong support for viewing alcohol use as a lifestyle issue to be dealt with in the context of a holistic approach to patient care. Participants cited many barriers to fulfilling their role and were particularly concerned about the appropriateness of asking *all* adolescent and adult patients about alcohol use, even at visits intended to discuss other issues and concerns. Physicians gave several motivations for improving their work in reduction of alcohol consumption, including their current frustration with the lack of a systematic strategy or tangible materials to help them identify and manage patients.

Conclusions: Interventions with patients who use alcohol should be framed in the context of a holistic approach to family medicine. Qualitative knowledge of the motivations and barriers affecting physicians can inform future research and educational strategies in this area.

Objectif : Préciser les motifs des médecins de famille en ce qui a trait à l'intervention rapide dans les cas de consommation d'alcool et les obstacles qu'ils perçoivent à ces interventions.

Conception : Étude qualitative fondée sur le recours à des groupes de discussion et des entrevues semi-structurées.

Contexte : Pratiques communautaires de médecine familiale rémunérée à l'acte de London (Ont.).

Participants : Douze participants à des groupes de discussion recrutés à la suite d'appels téléphoniques effectués par deux médecins de famille membres de l'équipe du projet. Les participants devaient pratiquer la médecine familiale à London. Douze participants interviewés ont été recrutés à la suite d'une séance scientifique hebdomadaire à deux hôpitaux locaux. Les participants devaient pratiquer dans une clinique familiale communautaire où les soins de première ligne n'étaient pas prodigués par des résidents et avoir consenti à participer à toutes les phases (p. ex., établissement des besoins, formation et évaluation) d'un programme de formation en intervention afin d'aider les patients à boire moins ou à cesser de fumer.

From the Social Evaluation and Research Department, Addiction Research Foundation of Ontario, University of Western Ontario, London, Ont.

***Reprint requests to:** Dr. Brian Rush, Social and Evaluation Research Department, Addiction Research Foundation, Gordon J. Mogenson Bldg., 200–100 Collip Circle, University of Western Ontario Research Park, London ON N6G 4X8*

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Principales mesures des résultats : Motifs d'intervention rapide en cas de consommation d'alcool et obstacles perçus à ces interventions, définis par les médecins.

Résultats : Les médecins membres des groupes de discussion et les médecins interviewés ont admis leur rôle lorsqu'il s'agit d'aider des patients à boire moins et ils ont mentionné plusieurs raisons qui justifient l'importance de ce rôle. Beaucoup étaient d'accord pour considérer la consommation d'alcool comme une question liée au style de vie qu'il faut aborder dans le contexte d'une démarche globale de soin des patients. Les participants ont cité de nombreux obstacles qui les empêchent de jouer leur rôle et se sont demandé surtout s'il convient d'interroger *tous* leurs patients adolescents et adultes au sujet de leur consommation d'alcool, même lorsque les patients consultent pour d'autres problèmes. Les médecins ont présenté de nombreuses raisons d'améliorer leurs efforts pour réduire la consommation d'alcool, y compris la frustration que provoque chez eux l'absence de stratégie systématique ou de documents concrets qui pourraient les aider à identifier et traiter les patients.

Conclusions : Les interventions auprès de patients qui consomment de l'alcool devraient s'inscrire dans le contexte d'une approche générale de la médecine familiale. Une connaissance qualitative des motifs des médecins et des obstacles qu'ils doivent surmonter peut éclairer des stratégies à venir de recherche et d'éducation dans ce domaine.

During the past decade a significant number of studies have demonstrated the value of family physicians' identification of and advice to patients who are consuming large amounts of alcohol.[1,2] Several clinical trials have shown that brief intervention by family physicians is effective in reducing alcohol consumption among patients who are not severely dependent on alcohol.[3,4] Given this evidence, there is a call for a more concerted and widespread effort to disseminate effective detection and management protocols to family physicians.[5] In Canada this challenge is being met through efforts to introduce medical education concerning abuse of alcohol and other substances[6] as well as through development and dissemination of patient protocols specifically designed for Canadian family physicians.[7]

To provide background information for this work with family physicians, researchers have examined the alcohol-related knowledge, attitudes and beliefs of physicians through surveys[8–11] and qualitative studies.[12–14] For example, cross-sectional surveys have consistently shown that family physicians acknowledge and endorse their role in the identification and management of patients who are drinking heavily or are beginning to experience alcohol-related problems.[8,10,15] However, surveys[10,11,15] and qualitative studies[13,14] have also shown consistently that physicians anticipate a poor prognosis when they choose to intervene with patients experiencing drinking problems. These studies have indicated that physicians feel ill-prepared by formal medical education for working with these patients. The studies that used a qualitative approach[13,14] highlighted physicians' difficulty in defining "drinking problems" and described the varied views of what constitutes "safe" or "at-risk" drinking. Intervention and referral methods have also been shown to vary widely.[14]

The problem being addressed in this research is that, although physicians' intervention to reduce their patients' alcohol use is effective, most physicians do not intervene.[5] This line of inquiry concerning alcohol consumption and the role and effectiveness of interventions by family physicians is paralleled by a body of research concerning smoking.[3–5] Studies that use qualitative methods such as focus groups and semistructured interviews have become increasingly important in this research because they help to clarify the potential barriers to widespread adoption of case-identification and early-intervention protocols from the perspective of family physicians.[13–16]

This article presents the results of the preliminary data-collection phase of a larger project recently completed in London, Ont. The purpose of the project was to demonstrate and evaluate a model for community-based training and continuing education (the health-facilitator model) designed in Britain.[17,18] This model has been used to assist family physicians in identifying and managing their patients who drink, smoke or engage in other lifestyle practices that are risk factors for disease. The researchers felt that it was necessary to understanding the perspective of a small group of family physicians on their patients' use of alcohol and tobacco before the model could be successfully implemented. A separate report describes the training model.[19]

Two types of qualitative interviews were employed. The first was the focus-group interview; two groups were conducted before the researchers had tailored the British model to the Canadian context. The second was the semistructured interview; these were conducted with physicians recruited for the training program. Results of the evaluation of the health-facilitator model will be presented elsewhere. This article describes the views of the physicians interviewed concerning (a) their role in identifying alcohol use by their patients, (b) approaches to patient management, (c) barriers to identification and management of patients and (d) motivations for learning better detection and management approaches. This research adds to the Canadian literature on family physi-

cians and substance abuse, and it complements a small body of qualitative research from Britain and Australia on similar issues.[13,14]

METHODS

FOCUS-GROUP INTERVIEWS

Focus groups have been well described and extensively used in health care research.[20–22] A focus group typically consists of 6 to 10 people with similar backgrounds assembled for a moderated interview lasting half an hour to 2 hours.[23,24] In the group setting issues are explored through interaction among the participants, rather than between the interviewer and the participants, which leads to "greater emphasis on participants' points of view."[23]

Two separate focus-group interviews were conducted with a combined convenience sample of 12 family physicians practising in London. These interviews were intended to provide an understanding of the diversity and range of physicians' views on and practice styles concerning intervention in alcohol use and to provide background information for the implementation of the facilitator model. The intent was not to measure the distribution of views or generalize the results to other family physicians.

The nonrepresentative sample of physicians was recruited by two physicians on the project team. The only requirements for participation in the focus groups were that the physicians be practising family medicine in London and be willing to provide 2 hours of their time for one interview. Potential participants were first contacted by telephone to determine their interest and availability. This telephone call was followed by a letter specifying the time and the location of the interviews, which were held at a research centre at the University of Western Ontario, London. The group discussion was guided by a nonphysician moderator. Topics included how the physicians identified patients whose health was at risk as a result of alcohol, drug or tobacco use, how these at-risk patients were managed and how physicians viewed their success in treating these patients. Each focus group lasted 2 hours; the discussions were tape-recorded and transcribed.

The interviews were analysed independently by the moderator and three members of the research team with the use of an editing style described by Crabtree and Miller[25] and based on a method developed by McCracken.[26] The process involved an extensive reorganization and interpretation of relevant segments of the text. From this process themes emerged, with minor themes forming components of broader themes. These interpretations and the objectives of the interviews guided the selection of broad themes for further exploration.

SEMISTRUCTURED INTERVIEWS

The 12 family physicians who participated in this phase were recruited through presentations about the facilitator-training program conducted during family-medicine rounds at two local hospitals. In two instances a participating physician who was a partner in a group practice subsequently recruited the other partners. Participants were required to be practising in family medicine in London, and they were required not to be in a teaching practice in which residents provide primary care. These physicians had also agreed to participate in the larger project, which involved pretraining interviews, a 2-hour training seminar, continuing consultation as needed and participation in an evaluation protocol. These physicians comprised a self-selected group interested in this specific approach to the identification and management of patients with substance-abuse problems. One of the physicians in this group had also participated in a focus-group interview.

We selected a semistructured-interview approach in order to achieve a detailed understanding of the practices of individual physicians. Each interview was approximately 30 minutes in duration and included questions about the physician's methods of identifying and managing patients who use alcohol and tobacco, his or her definition of success when working with these patients, problems specific to his or her practice, and his or her motivations for learning a better detection and management approach. The semistructured interviews were conducted by the facilitator, tape-recorded and transcribed. Analysis was conducted independently by the facilitator and another member of the research team with the use of the editing method described earlier. Once themes were identified from each interview, they were examined in all of the interviews with the use of cross-case analysis. This involved grouping answers to common questions from different physicians and analysing different perspectives on central issues. No attempt was made to quantify the frequency of each theme in the 12 interviews or the two focus groups, since the research was not intended to reach conclusions about how representative or generalizable these themes were.

Themes from the semistructured interviews were then combined with those from the focus groups to form a picture of the diverse perspectives on and practice styles concerning identification and management of patients who use alcohol, as described by these physicians.

RESULTS

Two female and 10 male physicians participated in the two focus-group interviews; three of the partici-

pants were in solo practice and nine in group practice. Their experience in general practice ranged from 3 to 39 years, with an average of 16 years. Participants saw from 90 to 200 patients per week, with an average of 130.

Two male physicians (55 and 57 years of age) and 10 female physicians (34 years of age on average) — 3 of the 12 in solo practice and 9 in group practice — participated in the semistructured interviews. Two physicians, who were partners in a group practice, worked part-time; the other 10 physicians practised full-time. The experience of these physicians ranged from 4 to 32 years, with an average of 13 years. The full-time practising physicians estimated their total patient load at 900 to 3000 patients (1433 on average).

We present the results in four areas that reflect the research questions; each area contains one or more themes that emerged from the qualitative analysis.

Physician's role in identifying alcohol use

One theme that emerged was that participants viewed the identification of patients who use alcohol as clearly within their role as family physicians. Furthermore, they felt that it was *important* that they try to fulfil this role and they viewed themselves as well suited to do so. However, the word "important" had different meanings for different participants.

[It's] really important . . . hopefully, patients understand that we care and we want to help — we are the perfect people to address this.

I consider it important, it's probably one of the most important entry points, you know, where you can catch what's going on. And I think if you don't ask about [it], you're not going to hear much.

The perceived importance of the family physician's role also involved the view that the family physician had the authority and credibility to ask about drinking.

We act as support, we act as people with information. At times we act as people with authority.

The perceived role of the family physician was broader than patient identification. The participants linked the importance of the family physician's role in reduction of alcohol consumption to the practice of holistic medicine — understanding the whole of what is going on in a patient's life.

I think it's a primary role. I think there probably isn't anybody else who is sort of focused on touching on all sorts of problems in any given person's life.

Many of these physicians had incorporated in their practice the idea that alcohol and tobacco consumption are lifestyle issues and are important to their patients' health.

I usually tell them that I'm concerned about the amount of drinking and I'll tell them why that might be a health concern and why that might be a lifestyle-type of concern.

Approaches to patient management

It was apparent from the focus-group discussions that these physicians tended not to refer patients who were drinking excessively to specialized substance-abuse services in the community. There was a strong preference for treating the patient in the context of holistic family medicine.

[If] you even suggest that maybe you should go somewhere else, they take that as a rejection and they have been rejected at other times in their life and they say, oh, no, my doctor is not going to deal with this big important thing. I find I have been forced into really trying to deal with these things as they come up and go looking for them.

This group of physicians were all aware of a family physician in the community who was a specialist in the treatment of addiction, and they viewed this as the ideal combination of a holistic approach and specialist care.

The important thing about that is you are still getting a family medicine type of approach no matter what the problem is.

Even when the physicians had sought out community-based treatment agencies, they still preferred those that provided services consistent with this holistic philosophy.

I like the program particularly. . . . It is more of a holistic approach to their problem.

Barriers to the identification and management of patients who use alcohol

The physicians described several problems concerning and barriers to identifying and managing these patients.

A theme that emerged from the focus groups and the semistructured interviews was that, despite asking some patients about alcohol, the physicians were *missing patients at risk*.

Despite my good try, I am not picking up all the people who are drinking.

[I'm] leaving certain populations of people out of my thinking.

There was also a major concern expressed by participants about the *appropriateness* of asking *all* adult patients

about such a sensitive topic. This was most evident among the physicians participating in the semistructured interviews, who were aware that the training program would recommend asking all adults about their alcohol use. For some, this concern involved a hesitation to introduce health promotion activities into a consultation scheduled for another purpose

I think I'm the right person to ask these questions. We're trying to figure out when it's appropriate to ask it. When you are talking about asking it of everyone who comes into the practice, [this] may be a problem depending on why someone came to visit me at a particular time and what conversation happens.

Some physicians expressed a concern about screening all of their patients as the opportunity arises because of the sensitive nature of alcohol use.

You don't want to drive the patient away on the first visit [by] asking too many questions.

Annual health exams — this is the one place where physicians are given permission to ask about tobacco and alcohol.

In the semistructured interviews physicians also identified time constraints as a barrier to asking about alcohol use.

You know, every patient takes up time, so like every time I go into the examining room I'm supposed to bring up alcohol and tobacco. I would love to do that. I think that would be great, but I'm not sure if I can see myself doing that. It's not very practical in a sense. I think I will make an unconscious preselection because of time.

Physicians expressed pessimism about their ability to help their patients reduce their drinking.

I am not sure that as a physician I stop anybody from doing anything.

The identification and help with alcohol problems are fraught, for me, with difficulty and frustration.

Finally, a small number of physicians identified barriers in the health system or society at large. One physician commented that being a female physician may be an obstacle in dealing with male patients. Another noted possible cultural barriers, and another cited frustration with a health care system that touts health promotion but is not "budging in terms of letting us do it." Another theme, particularly in the focus-group discussions, was the conflicting message that it was acceptable, if not beneficial to one's health, to drink alcohol.

Especially when you are bombarded with these studies showing [that] the people who drink the equivalent of one to two drinks per day have less morbidity, live longer.

Motivations to learn better detection and management approaches

In the semistructured interviews we probed physicians' motivations for learning how to improve their work in reducing patients' alcohol consumption. The main theme in the participants' comments was their frustration with the lack of a *systematic strategy* or *tangible materials* for patient identification and management.

I don't have a plan for alcohol. I don't have anything that I sort of go by.

I don't have anything specific related to alcohol . . . tangible.

Other motivations for learning a new approach were expressed by individual participants. These included to avoid "crisis-oriented intervention for alcohol," to learn about the different treatment programs in the community and to get "hooked into the system," to acquire skills transferable to other areas of patient care and to obtain feedback on performance.

Discussion

Some researchers have called for a more concerted and widespread effort to disseminate effective protocols for the detection and management of patients' alcohol use.[1,5] Our study explored physicians' motivations concerning and barriers to early intervention for alcohol abuse as part of a larger research and development program to improve the work of a small group of physicians in this area.[19] The results have important implications for this program as well as for the wider dissemination effort.

First, many of our findings complement data obtained from a representative survey of Canadian family physicians[10] and those collected in other countries with the use of qualitative methods.[13,14] In particular, the physicians' endorsement of their role in working with patients who drink alcohol and their strong perception that they are well suited to take on this role were shown in the previous studies as well as in ours. Our findings are also consistent with those of previous research showing physicians' concern about questioning patients on this taboo topic[13] and their low level of confidence in their ability to influence the drinking behaviour of their patients.[10,11,13] Roche, Guray and Saunders[14] have described the time constraints thought to inhibit physicians from working with these patients and the varying opinions about whether patients should be managed by a physician or be referred to specialist agencies. The findings from these studies have often been highlighted as some of the opportunities for and challenges to large-scale dissemination of early-intervention protocols.[15]

The results of our study go beyond the previous findings in three important aspects: the extent to which physicians' work in this area fits with a holistic approach to medicine, physicians' resistance to screening all patients as the opportunity arises and the variation in perceived motivations concerning and barriers to early intervention.

There was strong endorsement of the role of the family physician in detection of alcohol use and subsequent patient management within the context of a holistic approach to medicine. This endorsement stemmed partly from the physicians' acknowledgement of their unique position in the health care system and partly from a philosophic commitment to a holistic approach as the most appropriate way to respond to health concerns. Furthermore, this approach also seemed to influence physicians' referral patterns and their comfort level in using other community resources to help the patient. The strong bond among family physicians discourages interaction with others outside this group; this may restrict the use of alternative community sources of assistance for alcohol problems. Given these perspectives, medical educators seeking to improve the teaching and training of family physicians should make strong conceptual links among physicians' work concerning alcohol, health promotion in general and a holistic approach to family medicine.

Second, the almost unanimous view that asking *all* adolescent and adult patients about alcohol use, even during consultations scheduled for another purpose, is not practical or desirable should be acknowledged. The time constraints, the lack of financial incentive for health promotion and the feeling that alcohol use is a sensitive, taboo topic are only part of the concern. More important, our interpretation is that asking about alcohol use during consultations requested by the patient for other reasons is seen as inconsistent with a patient-centred approach to family medicine. Many physicians are uncomfortable bringing up issues that patients have not identified themselves.

Recent protocols, including one in Canada,[7] recommend that all patients be screened in order to establish baseline levels of alcohol consumption for each patient and to encourage physicians to link alcohol use and health risks at every opportunity. This presents a dilemma for those training family physicians in the use of these protocols. On the one hand, the recommendation is a legitimate strategy to discourage physicians from using selection criteria concerning who to ask about drinking, and when to ask, that effectively exclude early-stage problem drinkers. On the other hand, the resistance to screening at every opportunity must be acknowledged, and other strategies must be developed to ensure that alcohol use is probed in detail at least during the annual health examination or through office procedures to facilitate health checks (e.g., chart reminders).

Finally, although several identifiable themes and patterns emerged, the nuance and meaning in the physicians' expression of their perceived motivations and barriers varied. For example, the participants gave a strong endorsement of the role of family physicians; however, they gave a range of reasons why the role is important. Although there was a general concern about the appropriateness of asking all patients about alcohol use at every opportunity, the reasons for this view varied considerably. Similarly, the physicians recruited for the training program had a variety of motivations for learning better strategies for their work with patients who use alcohol.

Therefore, if educators and trainers wish to present a standard approach to detection and management of alcohol use by patients, the protocol must be tailored to the beliefs and needs of individual physicians. This variation also has important implications for the evaluation of training programs, since the outcomes may not be measurable with the use of grouped responses to standard scales or questions.

Although focus groups were suited to the aims of our study, the use of such groups had limitations. Participants were drawn from a small population of known physicians; therefore, it was impossible to ensure that the participants did not know one another. Their acquaintance may have limited their willingness to disclose their views.[23] In addition, the fact that the moderator was not a physician may have increased the risk that the participants' observations were less explicit than desired. In the semistructured interviews the participating physicians were self-selected volunteers; hence, their motivations for working with patients who drink alcohol or who have drinking problems may have been atypical. Their holistic views of family medicine may also have differed from those of the population of Canadian family physicians.

As we noted previously, owing to the methods used in this research, we do not claim that the results are representative or generalizable. However, they do provide valuable insights from physicians for program development and future research.

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Also in this issue are a review of the effectiveness of physician-based interventions with problem drinkers (see pages 851 to 859) and an accompanying editorial on whether physicians can identify and help problem drinkers (see pages 825 to 828).

References

1. Babor TF, Ritson EB, Hodgson RJ: Alcohol related problems in the primary health care setting: a review of early intervention strategies. *Br J Addict* 1986; 81: 23–46

2. Bien TH, Miller WR, Tonigan JS: Brief interventions for alcohol problems: a review. *Addiction* 1993; 88: 315–336

3. Richmond R, Anderson P: Research in general practice for smokers and excessive drinkers in Australia and the UK. I. Interpretation of results. *Addiction* 1994; 89: 35–40

4. Richmond R, Anderson P: Research in general practice for smokers and excessive drinkers in Australia and the UK. II. Representation of results. *Addiction* 1994; 89: 41–48

5. Richmond R, Anderson P: Research in general practice for smokers and excessive drinkers in Australia and the UK. III. Dissemination of interventions. *Addiction* 1994; 89: 49–62

6. Brewster JM, Single E, Ashley MJ et al: Preventing alcohol problems: survey of Canadian medical schools. *Can Med Assoc J* 1990; 143: 1076–1082

7. *Alcohol Risk Assessment and Intervention Project*, College of Family Physicians of Canada, Mississauga, Ont, 1994

8. Anderson P: Managing alcohol problems in general practice. *BMJ* 1985; 290: 1873–1875

9. Rohman ME, Clearly PD, Warberg M et al: The response of primary care physicians to problem drinkers. *Am J Drug Alcohol Abuse* 1987; 13: 199–209

10. Rush BR, Bass M, Stewart M et al: Detection, prevention and management of patient's alcohol problems by Canadian family physicians. *Can Fam Physician* 1994; 40: 1557–1566

11. Wechsler H, Levine S, Idelson RK et al: The physician's role in health promotion. A survey of primary care practitioners. *N Engl J Med* 1983; 308: 97–100

12. Clement S: Identification of alcohol-related problems by general practitioners. *Br J Addict* 1986; 83: 373–386

13. Thom B, Tellez C: A difficult business; detecting and managing alcohol problems in general practice. *Br J Addict* 1986; 81: 405–18

14. Roche AM, Guray C, Saunders JB: General practitioners' experiences of patients with drug and alcohol problems. [review] *Br J Addict* 1991; 86: 263–275

15. Rush BR, Ellis K, Crowe TG et al: How general practitioners view alcohol use: clearing up the confusion. *Can Fam Physician* 1994; 40: 1570–1579

16. Roche AM: Drug and alcohol professional education — alternative research strategies: focus groups. *Drug Educ J Aust* 1990; 4: 25–31

17. Fullard E, Fowler G, Gray M: Facilitating prevention in primary care. *BMJ* 1984; 289: 1585–1587

18. Fullard E, Fowler G, Gray M: Promoting prevention in primary care: controlled trial of low technology, low cost approach. *BMJ* 1987; 294: 1080–1082

19. Rush BR, Crowe TG, Powell LY et al: Substance abuse facilitator model: health promotion training for family physicians. *J Contin Educ Health Prof* (in press)

20. Wilms DG, Johnson NA, White NA: A qualitative study of family physician health promotion activities. In Crabtree BF, Miller WL (eds): *Doing Qualitative Research*, Sage Publications, Newbury Park, Calif, 1992: 189–204

21. Morgan DL: Doctor–caregiver relationships: an exploration using focus groups. In Crabtree BF, Miller WL (eds): *Doing Qualitative Research*, Sage Publications, Newbury Park, Calif, 1992: 205–227

22. Pucci LG, Haglund BJA: Focus groups: a tool for developing better health education materials and approaches for smoking intervention. *Health Promot Int* 1992; 7: 11–15

23. Morgan DL: *Focus Groups as Qualitative Research*, Sage Publications, Newbury Park, Calif, 1988

24. Krueger RA: *Focus Groups: a Practical Guide for Applied Research*, Sage Publications, Newbury Park, Calif, 1988

25. Crabtree BF, Miller WL (eds): A template approach to text analysis: developing and using codebooks. In *Doing Qualitative Research*, Sage Publications, Newbury Park, Calif, 1992: 93–109

26. McCracken G: *The Long Interview*, Vol 13 of *Qualitative Research Methods* series, Sage Publications, Newbury Park, Calif, 1988